State of Connecticut
Department of Public Health
Facility Licensing and Investigations Section

IN RE: Bloomfield Health Care Center of Connecticut, LLC of Bloomfield, CT.
Bloomfield Health Care Center
355 Park Avenue
Bloomfield, CT 06002

CONSENT AGREEMENT

WHEREAS, Bloomfield Health Care Center of Connecticut, LLC of Bloomfield, CT, (hereinafter the "Licensee") has been issued License No. 912-C to operate a Chronic and Convalescent Nursing Home known as Bloomfield Health Care Center (hereinafter the "Facility") by the Department of Public Health, (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter the "FLIS") of the Department conducted unannounced visits on various dates commencing on April 15, 2005 up to and including May 17, 2005 for the purpose of conducting multiple investigations and/or on August 23, through August 30, 2005 for the purpose of conducting multiple investigations and licensure and certification inspections; and

WHEREAS, the Department during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in the violation letter originally dated June 28, 2005 and amended on August 26, 2005 (Exhibit A – copy attached) and a violation letter dated October 7, 2005, (Exhibit B – copy attached); and

WHEREAS, an informal conference with respect to June 28, 2005 violation letter was conducted on July 19, 2005 at the office of the Department; and

WHEREAS, the Licensee, without admitting wrongdoing, is willing to enter into this Consent Agreement and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department of Public Health of the State of Connecticut acting herein and through ~~Marianne Horn~~ Joan Lovett, its Section Chief, and the Licensee, acting herein and through Marvin J. Ostreicher, its Managing Member, hereby stipulate and agree as follows:

1. The Facility's Administrator and the Director of Nursing Services shall meet with the Department every six (6) weeks for the first three (3) months after the effective date of this Consent Agreement and thereafter at twelve (12) week intervals. Said meetings shall include discussions of issues related to the care and services provided in the Facility and compliance with applicable federal and state statutes and regulations. The Medical Director shall attend initial meeting.
2. The Director of Nursing Service and/or Assistant Director of Nursing Service shall conduct random unannounced visits to the Facility to assess care/services being provided. Said visits shall occur on holidays, weekends and shall include all three (3) shifts. Documentation of observations relative to these visits shall be maintained and available for Department review, upon request.
3. Any records maintained or as required by this Consent Agreement shall be made available to the Department upon request and shall be retained for a period of three (3) years.
4. The Administrator shall immediately notify the Department if the position(s) of Administrator, Director of Nurses, Assistant Director of Nurses, Medical Director, Infection Control Nurse and/or MDS Coordinator become vacant. The Department shall be provided with weekly reports pertaining to recruitment efforts for any of the previously identified positions.
5. The Licensee represents, stipulates and agrees that at all times it will employ sufficient personnel to meet the needs of the patient population. The Licensee shall employ and appoint a free floating Nurse Supervisor on the 3-11 and 11-7 shifts who shall have previous supervisory experience. On the 7-3 shift, two Assistant Director of Nurses shall function as Nurse Supervisors. Nurse Supervisors shall have primary responsibility for the assessment of patients and the care provided by nursing staff. Nurse Supervisors shall not have patient

assignments and shall maintain a record of any patient related issue(s) or problem(s) identified on his or her shift and a notation as to the subsequent action taken to resolve the issue(s). Said records shall be made available to the Department upon request and shall be retained for a three (3) year period of time.

6. Within fourteen (14) days of the execution of this Consent Agreement the Licensee shall provide to such Nurse Supervisor the following:
    i. A job description which clearly identifies the supervisors' day-to-day duties and responsibilities;
    ii. A training program which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to patient and staff observations, interventions, staff remediation and Facility policies and procedures;
    iii. Nurse Supervisors shall be supervised and monitored by a representative of the Facility's Administrative Staff (e.g. Director of Nursing Service, Assistant Director of Nursing Service) to ensure the Nurse Supervisors are functioning in accordance with this Consent Agreement and state and federal requirements. Supervision by Administrative Staff shall be random and inclusive of evenings, nights, weekends and holidays. Records of such administrative visits and supervision shall be retained for the Department's review;
    iv. Nurse Supervisors shall be responsible for ensuring that all care is provided to patients by all caregivers in accordance with individual comprehensive care plans;
    v. Nurse Supervisors shall not be responsible for administrative functions such as securing staff; and
    vi. Nurse Supervisors shall be responsible for ensuring physician notification regarding changes in patient condition.
7. Within fourteen (14) days of the execution of this Consent Agreement the Director of Nurses shall develop and/or review and revise, as necessary, policies and procedures related to physical assessment of patients with peripheral vascular disease, pressure

ulcers, pressure ulcer prevention and treatment, documentation and tracking of pressure ulcers, care planning, interventions pertinent to pressure ulcers, turning and repositioning of patients and/or individual patient's needs, physician notification, documentation of physician notification, assessment and documentation for patients at risk for dehydration.

8. Within twenty-one (21) days of the effect of this Consent Agreement all Facility nursing staff shall be inserviced, to the policies and procedures identified in paragraph number 7.
9. The Facility shall contract with a credentialed Wound Care RN. The certified Wound Care RN shall serve a minimum of twenty (20) hours weekly for a six (6) month period and shall conduct training, provide oversight to nursing staff, maintain weekly statistics, observe all pressure sores, monitor preventative protocols and assess patients at risk for pressure sores or vascular sores.
10. The Department shall retain the authority to extend the period of the certified Wound Care RN functions are required, should the Department determine that the Facility is not able to maintain substantial compliance with federal and state laws and regulations pertinent to pressure ulcers. Examples of violations which may cause the Department to invoke this provision include, but are not limited to, failure to notify the physician of a significant change in skin condition, and/or failure to provide care and treatment to patients identified with skin integrity issues and/or failure to implement physician orders. Determination of compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.
11. The certified Wound Care RN contracted to provide wound care oversight shall provide a bi-weekly report to the Department regarding his/her responsibilities and an assessment of the Facility's progress as related to issues of skin integrity.
12. The Facility's medical staff shall review all policies and procedures related to skin integrity and shall document their examinations of all patients relative to impaired skin integrity.
13. The Facility shall establish a Quality Assurance Program to review patient care issues

inclusive of those identified in the June 28, 2005 and October 7, 2005 violation letters issued by the Department. The members of the Quality Assurance Program shall meet at least monthly to review and address the quality of care provided to residents and, if applicable, implement remediation measures. Membership shall at a minimum, include the Administrator, Director of Nurses, Infection Control Nurse, Nurse Supervisors and the Medical Director. Minutes of said meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.

14. Within seven (7) days of the execution of this Consent Agreement the Licensee shall identify the Facility's Administrative Staff responsible for monitoring the implementation of this document. The individual shall submit bi-weekly reports to the Department regarding the requirements of this Consent Agreement.
15. The terms of the Consent Agreement shall remain in effect for a period of two (2) years from the effective date of this document.
16. The Licensee shall pay a monetary fine to the Department in the amount of four thousand five hundred dollars ($4,500.00), which shall be payable be payable by money order or bank check to the Treasurer of the State of Connecticut and shall be posted to the Department within (2) weeks of the effective date of this Consent Agreement. The monetary penalty and any reports required by this document shall be directed to:

    Maureen Klett, R.N., SNC
    Facility Licensing and Investigations Section
    Department of Public Health
    410 Capitol Avenue, P.O. Box 340308
    MS #12HSR
    Hartford, CT 06134-0308

17. All parties agree that this Consent Agreement is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Agreement or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent

Agreement may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

18. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
19. The Licensee has had the opportunity to consult with an attorney prior to the execution of this Consent Agreement.

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IN WITNESS WHEREOF, the parties hereto have caused this Consent Agreement to be executed by their respective officers and officials, which Consent Agreement is to be effective as of the later of the two dates noted below.

BLOOMFIELD HEALTH CARE CENTER OF CONNECTICUT, LLC OF BLOOMFIELD, CT - LICENSEE

12/29/05
Date

By: _____
Marvin J. Ostreicher, Managing Member

STATE OF NY)

County of Nassau) ss December 29, 2005

Personally appeared the above named Marvin J. Ostreicher and made oath to the truth of the statements contained herein.

My Commission Expires: _____
(If Notary Public)

SCOTT STONE
Notary Public, State of New York
No. 02ST5008415
Qualified in Nassau County
Commission Expires February 22, 2007

_____
Notary Public [ ]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

1/4/06
Date

By: Joan D'Heault, Section Chief
~~Marianne Horn, R.N., J.D.~~, Section Chief
Facility Licensing and Investigations Section

Exhibit A

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

August 26, 2005

Ms. Audrey Cushing, Administrator
Bloomfield Health Care Center
355 Park Avenue
Bloomfield, CT 06002

Dear Ms. Cushing:

This is an amended edition of the violation letter originally dated June 23, 2005.

Unannounced visits were made to Bloomfield Health Care Center on April 15, May 10, 11, 12 and 17, 2005 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations with additional information received through June 15, 2005.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for July 19, 2005 at 2:00 PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut.

Please prepare a written Plan of Correction to be submitted to the Department by July 8, 2005.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

No referrals of health care professionals were initiated as a result of this inspection.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Diane Smith

Diane Smith, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

DMS:lsl

c. Director of Nurses
Medical Director
President
vlbloomfieldhclsl.doc
CT #3834, CT #4124

Phone:
Telephone Device for the Deaf: (860) 509-7191
410 Capitol Avenue - MS # _____
P.O. Box 340308 Hartford, CT 06134

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administration (3) and/or (j) Director of Nurses (2)(L) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(K).

1. Based on clinical record review and staff interviews, for a resident with a Stage II pressure ulcer, the facility was unable to provide documentation that the family had been notified when the pressure ulcer developed into a Stage IV ulcer. In addition when R #3 complained of difficulty seeing, the physician failed to be notified. The finding include:
    a. Resident #1 was admitted to the facility on 10/19/04 with diagnoses that included discitis, peripheral vascular disease, end stage renal disease and was receiving hemodialysis three times a week. The resident assessment dated 10/19/04 identified that the resident had impaired cognition, back pain, required limited assistance with bed mobility, was non-ambulatory and had no pressure ulcer. Review of the care plan dated 11/5/04 indicated that the resident had developed a 5.5cm fluid filled blister to the left outer heel secondary to friction with interventions that included a dressing change every day, puff boots every shift and to assess the area for sign and symptoms of infection or deterioration on a daily basis. Review of a weekly nursing skin integrity assessment sheet dated 11/4/04 to 3/1/05 indicated that the blister on the left outer heel had gone from a Stage 2, dry white tough skin to a Stage 4, (on 1/10/05), thick dry black tissue, and had increased in size on 2/1/05 (4 x 3cm), 2/8/05 (5 x 3.5cm), 2/14/05 (5 x 2cm) and on 2/21/05 (6cm). Review of a weekly nursing skin integrity assessment sheet dated 2/24/05 indicated that the resident had developed a Stage IV, 1.5 x 1cm dry black area, to the fourth toe of the left foot and on 3/1/05 the area on the toe had increased in size to 2 x 1cm, and was draining a moderate amount of bloody drainage. Although a review of the twenty-four report sheet dated 2/17/05 indicated that the family was aware of the left heel area and was questioning the staff as to why the"black" heel was not being treated, a review of the clinical record failed to identify that a response had been given to the family. Review of the clinical record dated 2/24/05 indicated that the family and physician were notified of the black area on the fourth toe of the resident's left foot with physician's orders on 2/28/05, 3/1/05, and 3/3/05 for dressing changes, doppler studies and an antibiotic. Review of a physician's progress note dated 3/1/05 indicated that the resident's wife had been informed that the resident had no palpable pulse to the left foot and that the physician felt that the foot maybe ischemic and that the resident was a poor surgical risk. Further review of a

physician's progress note dated 3/4/05 indicated that the family was informed that the left lower limb was worsening and that the situation was not reversible unless the limb was amputated. Subsequently the resident was transferred to the hospital on 3/4/05 and admitted with dry gangrene to the left heel, wet gangrene to the left toes and expired on 3/6/05 due to sepsis from the gangrene foot. Person #1 stated during interview on 4/22/05 at 1:30 PM that she was aware that the resident had developed a blister to the left heel on 11/4/04 but was never notified in January and/or at any other time prior to 2/17/05 that there had been a change in status to the resident's heel ulcer. The Unit Manager, on 4/29/05 at 1:50 PM, stated that the family had been updated regarding the changes in the resident's heel ulcer, but a review of the clinical record dated 1/10/05 to 2/24/05 failed to identify that the family had been notified of the changes to the resident's heel ulcer. MD # 1/Medical Director on 5/5/05 at 3:35 PM stated that he had not had a discussion with the family regarding any other interventions to the residen't left heel (during the period of 11/5/04 through 2/28/05) did not have the resident seen by a vascular physician prior to 3/1/05.

b. Resident #3's MDS assessment dated 2/8/05 identified the resident as being cognitively impaired, requiring total care by staff for all needs. Diagnoses included insulin dependent diabetes mellitus, optic neuritis with diminished vision and multiple sclerosis with partial paraplegia. The care plan dated 2/8/05 identified impaired visual functioning with vision loss of the right eye due to optic neuritis and probably glaucoma. Nurse's notes dated 5/3/05 identified that the resident complained of having difficulty seeing out of her left eye at times. Documentation was lacking that the physician was notified. Interview with the Administrator and DNS on 5/12/05 and 5/18/05 identified that the situation resolved because the resident never complained about this again. Documentation was lacking to that there was discussion with the resident during the period of 5/4/05 through 5/12/05 by facility staff and/or that a consultation was scheduled to check the resident's left eye vision. Interview and record review with the Director of Nurses identified no eye evaluation and/or consultation could be found in the resident's medical record.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical records (2)(H).

2. Based on clinical record review and staff interviews, for a resident (R #1) who developed a left heel pressure ulcer, documentation was lacking to identify that the resident was reassessed for additional and/or alternative approaches to the problem when the resident refused to keep the puffs boots on and/or had developed a Stage IV pressure ulcer and/or had increased in size. In addition, the facility failed to revise the care plan for Resident #3 to address the complaint of left visual difficulty, and/or interventions to address the resident's non-compliance with repositioning and/or request to go to another facility. The findings include:
    a. Resident #1 was admitted to the facility on 10/19/04 with diagnoses that included discitis, peripheral vascular disease, end stage renal disease and was receiving hemodialysis three times a week. The resident assessment dated 10/19/04 identified that the resident had impaired cognition, back pain, required limited assistance with bed mobility, was non-ambulatory and had no pressure ulcers. Review of the care plan dated 11/5/04 indicated that the resident had developed a 5.5cm fluid filled blister to the left outer heel secondary to friction with interventions that included a dressing change every day, puff boots every shift and to assess the area for signs and symptoms of infection or deterioration on a daily basis. Review of the nurse's notes dated 11/4/04 to 2/27/05 indicated that the resident refused to keep the puff boots in place on 11/8/04 and on 2/1/05. The Unit Manager on 4/29/05 at 1:50 PM stated that when the resident refused to keep the puff boots on, the resident's heels were elevated on a pillow, and the foot of the bed was padded. A review of the resident's care plan indicated that documentation was lacking to identify that the resident was reassessed for additional and/or alternative approaches when the resident refused to keep the puffs boots on. The Unit Manager on 4/29/05 at 1:50 PM stated that she and the nurses on the unit are responsible to update and make revisions to the care plan. Additionally, review of a weekly nursing skin integrity assessment sheet dated 1/10/05 indicated that the blister on the left outer heel had gone from a Stage 2, dry white tough skin to a Stage 4, thick dry black tissue. Further review of the weekly nursing skin integrity sheet indicated that the pressure ulcer to the left heel had increased in size on 2/1/05 (4 x 3cm), 2/8/05 (5 x 3.5cm), 2/14/05 (5 x 2cm) and on 2/21/05 (6cm). A review of the resident's care plan indicated that documentation was lacking that revisions had been made to reflect that the

resident had been reassessed for additional and/or alternative approaches when the heel ulcer developed into a Stage IV pressure ulcer on 1/10/05 and/or when there was an increase in size to the heel ulcer on 2/1/05, 2/8/05, 2/14/05 and 2/21/05. LPN #1 on 5/5/05 at 1:30 PM stated that a daily dry clean dressing change to the left heel and puff boots was started on 11/4/04 as a nursing measure but in December 2004, after attending a seminar on pressure ulcer, nursing had made a decision to keep the ulcer area open to air versus covering the area with a dressing. The Unit Manager on 4/29/05 at 1:50 PM stated that she and the nurses on the unit are responsible to update and make revisions to the care plan.

b. Resident #3's MDS assessment dated 2/8/05 identified the resident as being cognitively impaired, requiring total care by staff for all needs. Diagnoses included insulin dependent diabetes mellitus, optic neuritis with diminished vision and multiple sclerosis with partial paraplegia. The care plan dated 2/8/05 identified impaired visual functioning with vision loss of the right eye due to optic neuritis and probably glaucoma. Nurse's notes dated 5/3/05 identified that the resident complained of having difficulty seeing out of her left eye at times. Documentation was lacking that the physician was notified and/or that revisions to the care plan were made to address this new left visual problem. Interview with the Administrator and DNS on 5/12/05 and 5/18/05 identified that the situation resolved because the resident never complained about this again. Documentation was lacking to identify that there was another discussion with the resident during the period of 5/4/05 through 5/12/05 by facility staff and/or that a consultation was scheduled to check the resident's left eye vision. The DNS could not provide documentation that the resident's vision had been evaluated while in the facility.During the interview on 5/18/05, the facility presented a note on the 2/8/05 care plan that the vision problem was being rewritten, but did not provide the new rewritten care plan. Upon contact with the Administrator on 5/24/05 the same original care plan was faxed without any new interventions. In addition, Resident #3's MDS assessment dated 2/8/05 identified the resident as being cognitively impaired, requiring total care by staff for all needs and had a stage three pressure ulcer. Diagnoses included insulin dependent diabetes mellitus, optic neuritis with diminished vision and multiple sclerosis with partial paraplegia. The care plan dated 2/8/05 identified that on 8/17/04 the resident was identified as non-compliant with repositioning and had a stage three pressure ulcer of the buttocks/coccyx. Although the care plan had interventions which included turning/position every two hours, treatments as ordered, assess daily for signs and symptoms of infection or deterioration of area, bedrest, side to side and

on back for meals, interventions to address the non-compliance with repositioning were not addressed. The only intervention to address non-compliance was to encourage dietary compliance. A review of nurse's notes during the period of 4/4/05 through 5/11/05 identified three occasions in which the resident refused care and/or repositioning on 4/18/05, 5/1/05 and 5/5/05. In addition, Resident #3's MDS assessment dated 2/8/05 identified the resident as being cognitively impaired, requiring total care by staff for all needs and a stage three pressure ulcer. Diagnoses included insulin dependent diabetes mellitus, optic neuritis with diminished vision and multiple sclerosis with partial paraplegia. A review of the resident's social service note dated 4/21/05 identified that Resident #3 stated to the Social Worker that she "Wants out of the facility". The care plan lacked a plan to address this issue and a review of the social service notes for the period of 4/22/05 through 5/12/05 lacked documentation that additional discussions with this resident occurred. Interview and record review with the Administrator, DNS, ADNS and Corporate Nurses could not provide additional documentation and/or follow-up to address this issue. On 5/18/05 facility staff identified that the social worker on 4/21/05 made suggestions for coping (not on care plan) with frustrations and discussed placement options. Resident #3's MDS assessment dated 2/8/05 identified the resident as being cognitively impaired, requiring total care by staff for all needs. Diagnoses included insulin dependent diabetes mellitus, optic neuritis with diminished vision and multiple sclerosis with partial paraplegia. The care plan dated 2/8/05 identified impaired visual functioning with vision loss of the right eye due to optic neuritis and probably glaucoma. Nurse's notes dated 5/3/05 identified that the resident complained of having difficulty seeing out of her left eye at times. Documentation was lacking that the physician was notified and/or that revisions to the care plan were made to address this new left visual problem. Interview with the Administrator and DNS on 5/12/05 and 5/18/05 identified that the situation resolved because the resident never complained about this again. Documentation was lacking to identify that there was another discussion with the resident during the period of 5/4/05 through 5/12/05 by facility staff and/or that a consultation was scheduled to check the resident's left eye vision. The DNS could not provide documentation that the resident's vision had been evaluated while in the facility. During the interview on 5/18/05, the facility presented a note on the 2/8/05 care plan that the vision problem was being rewritten, but did not provide the new rewritten care plan. Upon contact with the Administrator on 5/24/05 the same original care plan was faxed without any new interventions. In addition, Resident #3's MDS assessment

dated 2/8/05 identified the resident as being cognitively impaired, requiring total care by staff for all needs and had a stage three pressure ulcer. Diagnoses included insulin dependent diabetes mellitus, optic neuritis with diminished vision and multiple sclerosis with partial paraplegia. The care plan dated 2/8/05 identified that on 8/17/04 the resident was identified as non-compliant with repositioning and had a stage three pressure ulcer of the buttocks/coccyx. Although the care plan had interventions which included turning/position every two hours, treatments as orders, assess daily for signs and symptoms of infection or deterioration of area, bedrest, side to side and on back for meals, interventions to address the non-compliance with repositioning were not addressed. The only intervention to address non-compliance was to encourage dietary compliance. A review of nurse's notes during the period of 4/4/05 through 5/11/05 identified three occasions in which the resident refused care and/or repositioning on 4/18/05, 5/1/05 and 5/5/05. In addition, Resident #3's MDS assessment dated 2/8/05 identified the resident as being cognitively impaired, requiring total care by staff for all needs and a stage three pressure ulcer. Diagnoses included insulin dependent diabetes mellitus, optic neuritis with diminished vision and multiple sclerosis with partial paraplegia. A review of the resident's social service note dated 4/21/05 identified that Resident #3 stated to the Social Worker that she "Wants out of the facility". The care plan lacked a plan to address this issue and a review of the social service notes for the period of 4/22/05 through 5/12/05 lacked documentation that additional discussions with this resident occurred. Interview and record review with the Administrator, DNS, ADNS and Corporate Nurses could not provide additional documentation and/or follow-up to address this issue. On 5/18/05 facility staff identified that the social worker on 4/21/05 made suggestions for coping (not on care plan) with frustrations and discussed placement options.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

3. Based on clinical record review and staff interviews, for one of two residents who had peripheral vascular disease, documentation was lacking to reflect that the resident's circulation, sensation and pedal pulses were assessed and/or for two residents (Resident #2 and Resident #10) who required total care by staff for repositioning, the care plan

positioning regime failed to meet standard of care, and/or the facility failed to ensure that physician orders were obtained for Resident #18. The finding include:

a. Resident #1 was admitted to the facility on 10/19/04 with diagnoses that included discitis, peripheral vascular disease, end stage renal disease and was receiving hemodialysis three times a week. The resident assessment dated 10/19/04 identified that the resident had impaired cognition, back pain, required a limited assistance with bed mobility, was non-ambulatory and had no pressure ulcers. The care plan dated 11/5/04 indicated that the resident had developed a 5.5cm fluid filled blister to the left outer heel secondary to friction with interventions that included a dressing change every day, puff boots every shift and to assess the area for sign and symptoms of infection or deterioration on a daily basis. A weekly nursing skin integrity assessment sheet dated 1/4/05 indicated that R #1 had developed a scabbed area to the fourth toe on the left foot, measuring 1.5cm x 0.5cm, possibly black in color to a no scabbed area on 2/1/05. Review of a weekly nursing skin integrity assessment sheet dated 2/24/05 indicated that the resident had developed a Stage IV, 1.5 x 1cm dry black area, to the fourth toe of the left foot and on 3/1/05 the area on the toe had increased in size to 2 x 1cm, and was draining a moderate amount of bloody drainage. Although the Unit Manager on 4/29/05 at 1:50 PM stated the resident's left foot was being monitored and assessed daily for temperature changes and pulses and that the area on the resident's fourth toe broke down very quickly, a review of the clinical record dated 2/2/05 to 2/23/05 lacked documentation to reflect that the toe had been monitored and assessed before developing into a Stage IV stasis ulcer. According to the Lippincott Manual of Nursing Practice, Seveth Edition, 2001, a nursing assessment of the peripheral vascular system of a patient who may have a peripheral vascular disorder would include a focus on appearance and temperture of the skin, location and appearance of the ulcer, determine presence and quality of all peripheral pulses, and observe for drainage and signs of infection. Subsequently, on 2/24/05, R #1 developed a Stage IV stasis ulcer, dry black area to the fourth toe of the left foot, measuring 1.5 x 1cm in size. The family and physician were notified but there were no new orders. Review of a treatment note dated 2/28/05 indicated that the stasis ulcer on the fourth toe was open, had bloody drainage and was more black in color and that the physician was notified with orders for a dressing change to be done daily and doppler studies. Subsequently, on 3/1/04, the stasis ulcer on the fourth toe increased in size to 2 x 1cm and had a moderate amount of bloody drainage. The physician was notified and new orders were obtained for arterial testing, pain medication and an

antibiotic which was started on 3/3/05. Review of a physician's progress note dated 3/1/05 and 3/4/05 indicated that the family was informed that the left lower limb was worsening and that the situation was not reversible unless the limb was amputated.

b. Resident #2's Minimum Data Assessment dated 12/13/04 and the MDS assessment dated 3/12/05 identified the resident as severely cognitively impaired, unable to make self understood, required total care by staff for all needs, had a pressure ulcer and was incontinent of bowel and bladder. The care plan dated 12/23/04 and 3/24/05 identified that the resident was at risk for alteration in skin integrity due to immobility and incontinence with interventions that included to turn, reposition every two to three hours and prn, perform skin assessments as per policy and notify MD of any problems. Following the administration of incontinent care, NA #5 placed the resident on the left side. Constant observation of the resident on 5/10/05 during the period of 5:50 AM through 9:00 AM identified that the resident failed to be repositioned off her left side for a total of three hours and ten minutes. At 9:05 AM the resident was positioned on her back. The care plan failed to meet the standard of care by directing staff that the resident could be turned every two to three hours. According to "Patient Care Standards", Seventh Edition (2000) when a patient is at risk for impaired skin integrity related to physical immobilization, preventive measures included turning the patient every two hours to relieve pressure.

c. Resident #10's MDS assessment dated 4/25/05 identified the resident as cognitively impaired, incontinent of urine and stool and requiring total care by staff for all needs. The care plan dated 4/26/05 identified that the resident required total care. An intervention included to turn and position every two to three hours and PRN. Observation of the resident on 5/10/05 during the hours of 6:10 AM through 8:26 AM reflected that the resident was lying on the left side. Interview with NA #5 the aide who provided care to this resident identified that she finished with care in that resident's room at around 5:15 AM. The resident failed to be repositioned off her left side from approximately 5:15 AM to 8:26 AM for a period of three hours. The care plan failed to meet the standard of care by directing staff that the resident could be turned every two to three hours. According to "Patient Care Standards", Seventh Edition (2000) when a patient is at risk for impaired skin integrity related to physical immobilization, preventive measures included turning the patient every two hours to relieve pressure.

c. Resident # 18 (R # 18) was admitted to the facility on 5/6/05. Review of the medical record identified that the resident was admitted with a Stage II area on the

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

coccyx that was treated with Lanaseptic cream every shift. Review of the Medication Administration Record (MAR) identified that on 5/9/05, treatment to R #18's coccyx wound was changed to include cleansing with normal saline followed by Xenaderm and a dry clean dressing. Review of the medical record lacked documentation to reflect that a physician order had been obtained. Interview with LPN #3 on 5/17/05 identified that MD #1 had given her the order on 5/9/05 and that she had forgotten to write it on the physician order sheet. Subsequent to surveyor inquiry on 5/17/05, a physician order for the treatment was obtained and transcribed into the record by LPN #3. Review of the progress notes dated 5/17/05 identified documentation by MD #1 that he had ordered the new treatment on 5/9/05, that the instructions had been transcribe onto the treatment kardex, but that the order had apparently not been transcribed into the chart.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

4. Based on review of the medical record, interviews, and observation, the facility failed to ensure that a wound treatment for one resident, Resident #2 was done in accordance with physician's orders. The findings included:
   a. Resident #2 (R #2) had diagnoses that included ischemic ulcers of the left foot. Review of the physician's order sheet dated 2/8/05 identified treatment orders for Misoprostyl cream to be applied to the resident's left foot and heel after cleansing, followed by a non-stick dressing and a gauze wrap three times daily. Review of the nursing notes dated 5/16/05 identified that the facility "ran out of Misoprostyl cream today" and that only a dry clean dressing was applied. Interview with Person #3 on 5/17/05 identified that the nurse who applied the dressing on 5/16/05 told her that there was no more Misoprostyl cream and that more had been ordered. Interview with RN #1 on 5/18/05 identified that the Misoprostyl cream was actually in the refrigerator on 5/16/05 and that the evening nurse did not see it. Observation of the Misoprostyl cream container identified that the prescription had been filled on 5/11/05.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

5. Based on clinical record reviews, review of nurse aide assignments and staff interviews, for two residents (R #1, R #7), documentation was lacking to identify that the residents had been assessed for signs and symptoms of dehydration in accordance with the resident's plan of care and/or that Skin Prep had been applied to the resident's heels. The findings include:
    a. Resident #1 was admitted to the facility on 10/19/04 with diagnoses that included discitis, peripheral vascular disease, end stage renal disease and was receiving hemodialysis three times a week. The resident assessment dated 10/19/04 identified that the resident had impaired cognition, back pain, required a limited assistance with bed mobility, was non-ambulatory and had no pressure ulcers. The resident care plan dated 10/25/04 indicated that the resident was on a 1200cc fluid restriction and was at risk for dehydration with interventions that included to evaluate and monitor for signs and symptoms of dehydration including confusion, constipation, cracked lips, electrolytes imbalance, fever, dry mucous membranes, poor skin turgor, decreased urine output, weakness, weight loss and to monitor the resident's intake and output. Review of the nutritional progress notes dated 10/21/04 to 1/20/05 indicated that the resident had an admission weight of 149.6 pounds (ideal body weight: 157 pounds) and a weight of 120.8 pounds on 1/3/05 showing a 28.6 pound weight loss. Review of the Advanced Directive dated 12/21/04 identified that no intravenous or parenteral feedings be administered to the resident. Further review of a nutritional note dated 12/3/04 indicated that R #1's fluid restriction was increased to 1500cc and the diet included a protein supplement (Nepro) 240cc twice a day. Review of the nurses notes dated 10/21/04 to 3/1/05 indicated that R #1's appetite was poor for a total of thirty four (34) days. Review of the intake and output sheets dated 2/1/05 to 3/3/05 indicated that R #1's fluid intake ranged from no intake on 2/2/05 and 2/7/05 to a total of twenty (20) days in which the fluid intake ranged between 440cc to 960cc. Review of the Vital Sign Record dated 10/22/04 to 3/4/05 indicated that the resident's vital signs were monitored daily and R #1's temperature ranged between 96.1 to 100.4. Review of an emergency department record dated 2/13/05 indicated that the resident had fallen at the facility and was transferred to the emergency department for an evaluation. The emergency department record dated 2/13/05 indicated that the resident had sustained no injuries but was

emaciated and had dry mucous membranes. Review of a dialysis record dated 2/15/05 indicated that the resident looked dehydrated. Although the facility is currently utilizing an intake and output sheet that includes to monitor the resident's mucous membranes and urine for odor, a review of the clinical record dated 10/19/04 to 3/4/05, lacked documentation to reflect that R #1 had been assessed for signs and symptoms of dehydration to include, monitoring of cracked lips, poor skin turgor, dry mucous membranes and weakness in accordance with the resident's plan of care.

b. Resident #7 was admitted to the facility on 6/18/04 with diagnoses that included cerebral vascular accident and a non-insulin diabetic. R #7's quarterly assessment dated 3/23/05 identified that the resident had impaired cognition, was totally dependent on staff for all activities of daily living and had no pressure sores. The resident care plan dated 3/29/05 indicated that the resident was at risk for alteration in skin integrity with interventions that included to observe the resident's feet for any evidence of foot problems (ie: reddened areas, black spots, ulcers, mycotic nails, bunions), and to apply TED stockings on in the AM and off at bedtime. Review of the nurse aide assignment dated 5/6/2005 indicated that all nurse's aides are to put Skin Prep on the resident's heels when their skin is intact, during AM care and bedtime care. Observations made on 5/10/05 at 6:00 AM during R #7's AM care, indicated that R #7 had a purple/bluish darken area to the right heel. Further observations made on 5/10/05 at 6:00 AM indicated that after bathing R #7, NA #1 applied R #7's TED stockings and shoes without the benefit of using any Skin Prep to the resident's heels and/or without noticing that the resident had a purple/bluish area on the right heel. Subsequent, upon surveyor's inquiry, an observation was made with the Unit Manager, RN #1, on 5/10/05 at 1:05 PM indicated that R #7 had a 6 x 1.3 cm soft darken area to the right heel. RN #1 stated that the nurse's aides are responsible to apply Skin Prep to the resident's heels during AM care and at bedtime and to notify the nurse of any redden and/or skin break down. Review of the inservice sheets dated 4/18/05, 4/25/05 and 4/28/05 on Heel Breakdown, indicated that NA #1 had not attended any of the inservices. Several unsuccessful attempts have been made to contact NA #1. The Director of Nurses on 5/10/05 at 3:30 PM stated that the nurse's aides applying Skin Prep to the resident's heels was just implemented a couple of weeks but that the supervisors are responsible to make sure that all nurse aides on their shift are aware of the new protocol.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1)(B) and/or (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (2)(B) and/or (2)(C).

6. Based on observations, clinical record reviews and interviews, the facility failed to implement preventive interventions for a resident's (R #1) left heel pressure ulcer, and/or to reposition residents (R #2, R #3, R #4, R #5) who were identified with pressure ulcers, every two hours and/or documentation was lacking a physician evaluation and/or that new interventions were promptly implemented when the residents' (R #3, R #4) pressure ulcers increased in size, and/or depth, and/or had an odor, and/or necrosis and/or new drainage. The findings include:
    a. Resident #1 was admitted to the facility on 10/19/04 with diagnoses that included discitis, peripheral vascular disease, end stage renal disease and was receiving hemodialysis three times a week. The resident assessment dated 10/19/04 identified that the resident had impaired cognition, moderate back pain, required a limited assistance with bed mobility, was non-ambulatory and had no pressure ulcers. Review of the care plan dated 10/25/04 indicated that R #1 was at risk for increased alteration in skin integrity with interventions that included to elevate heels off the bed and an air overlay mattress. Review of a treatment note dated 11/4/04 indicated that R #1 had developed a 5.5cm fluid filled blister to the left outer heel secondary to friction with nursing interventions that included a dressing change every day, puff boots at all times and to monitor the left heel for signs and symptoms of infection and deterioration on a daily basis. Treatment notes dated 11/4/04, 11/8/04, 1/4/05 and 1/10/05 identified that R #1 utilized "Bunny boot" on heels. Review of the weekly Nursing Skin Integrity Assessment sheet dated 11/4/04 to 12/8/04 lacked documentation to reflect that the blister had been staged as a Stage II for a total of five weeks in accordance with the facility's policy. Review of the facility's policy on Skin Integrity under the guidelines for documenting wounds indicated that a Stage II pressure ulcer is a partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents chronically as an abrasion, blister, or shallow crater. The facility failed to provide appropriate interventions and/or care and treatment to an existing pressure ulcer. Although facility staff (Administrator and DNS) identified that MD #1/Medical Director had made rounds and did evaluate all pressure ulcers, the clinical record lacked this information and any documentation of physician evaluation of the treatment regime. Review of the clinical record (physician's progress notes) and/or interview with MD #1/Medical Director, Administrator and

the DNS, indicated that R #1 developed stasis ulcers and sudden severe vascular changes to the left foot and/or left lower limb at the end of February into March 2005 and MD #1/Medical Director informed the family that the condition was not reversible unless the limp was amputated. The physician's progress notes dated 1/11/05 and 2/17/05 identified that R #1 was comfort measures only. Subsequently, upon the request of the family, R #1 was transferred to the hospital on 3/4/05 and admitted with left leg gangrene and dry gangrene of the left heel. Review of the hospital discharge summary record dated 3/6/05 indicated that R #1 had a grossly infected weeping left foot, foul smelling and that R #1 was mildly toxic and had decreased responsiveness. Further review of the hospital records dated 3/4/05 indicated that the family had refused amputation and subsequently R #1 expired on 3/6/05 due to sepsis from a gangrene foot. Review of the Autopsy report dated 3/8/05 indicated that the resident had generalized severe atherosclerosis that included severe peripheral vascular disease affecting the left lower extremity. A written statement by MD #1/Medical Director dated 5/17/05 identified that he was kept abreast of the condition of Resident #1's left lower extremity during the months of January and February of 2005 and had knowledge of the blackened left heel and did not order any treatment to the area because it was chronic and stable. In addition, review of a weekly nursing skin integrity assessment sheet dated 1/10/05 indicated that the blister on the left outer heel had gone from a Stage 2, dry white tough skin to a Stage 4, thick dry black tissue but lacked documentation to reflect that the physician had been notified of the change and/or that any new interventions had been implemented. In addition, further review of the weekly nursing skin integrity sheet indicated that the pressure ulcer to the left heel had increased in size on 2/1/05 (4 x 3cm), 2/8/05 (5 x 3.5cm) and on 2/21/05 (6cm) but a review of the clinical record lacked documentation that the physician had evaluated the left heel pressure ulcer and/or that any new interventions had been implemented when the left heel ulcer increased in size. Interview with MD #1/Medical Director on 5/5/05 at 3:30 PM identified that he had not consulted with a surgeon and/or a vascular surgeon regarding R #1's left heel pressure ulcer during the period of 11/4/04 through 2/28/05. In addition, in a written statement dated 5/17/05 MD #1/Medical Director identified that he did not order any treatments to the area (left heel pressure ulcer) "because it was chronic and stable". MD #1/Medical Director further identified that the left heel was a pressure ulcer and in his opinion was best treated with a pressure boot and did not merit other interventions. In addition, the record lacked identification that MD #1/Medical Director discussed with R #1's family the treatment options

concerning the left heel pressure ulcer during the period of 11/4/04 through 2/17/05. The facility's twenty-four hour report sheet dated 2/17/05 (3-11) shift identified that the family questioned the staff as to why they were not treating R #1's "black heel". A review of the clinical record lacked any intervention and/or that preventative measures were implemented. Facility staff and/or MD #1/Medical Director failed to document in Resident #1's record, clinically valid reasons why no interventions were implemented and/or feasible to a resident with an identified Stage IV pressure ulcer of the left heel during the period of 1/10/05 to 3/4/05. Upon interview with the facility staff (DNS, Administrator, Corporate Nurse, and Director of Clinical Operations) on 5/18/05 they identified that because of R #1's diagnosis of peripheral vascular disease the physician did not want to debride the ulcer (stage IV pressure ulcer) on the heel which would place R #1 at risk for an infection. Doppler studies were done after a black stasis ulcer developed on the left toe. (Doppler ordered 2/28/05). In addition, LPN #1 on 5/5/05 at 1:30 PM stated that a daily dry clean dressing change to the left heel and puff boots was started on 11/4/04 as a nursing measure. LPN #1 stated that in December 2004, after attending a seminar on pressure ulcer, nursing had made a decision to keep the ulcer area open to air versus covering the area with a dressing. LPN #1 stated that MD #1/Medical Director was aware of the treatment change although there were no physician's orders for a daily dressing change to the left heel. MD#1/Medical Director on 5/5/05 at 3:35 PM stated that he had not discussed any other options regarding R #1's heel ulcer with the family prior to March 2005. MD #1/Medical Director further indicated that he had not requested a referral to a vascular surgeon or vascular studies prior to 3/1/05. MD #1/Medical Director stated that R #1 was comfort measures only although there was no physician's order to identify this, the physician's progress notes dated 1/11/05 and 2/17/05 identified that R #1 was comfort measures only and that the family's Advanced Directives for R #1 included no intravenous hydration, no artificial feeding, no intravenous antibiotics, do not hospitalize and do not resuscitate. MD #1/Medical Director further identified in an interview that if he ordered a new treatment to the pressure sore it would be written as a physician's order. Staff knew more about what treatment to do than he did. Although interview with MD #1/Medical Director identified that staff are always calling him about changes in skin condition, the medical record lacked any communication between nursing staff and the physician when there was a deterioration (when the tissue became necrotic and had an increase in size) in the resident's pressure ulcer.

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b. Resident #5 diagnoses included cerebral vascular accident and peripheral vascular disease. The resident care plan dated 3/30/05 identified the resident with impaired cognition and totally dependent on staff for all activities of daily living. Review of a resident care plan dated 3/30/05 indicated that the resident was a risk for alteration in skin integrity secondary to incontinence, poor oral intake, immobility and peripheral vascular disease with interventions that included to turn and reposition the resident every two to three hours, utilize an air mattress on the bed, and foam boots at all times. Review of a Nursing Skin Integrity Assessment sheet dated 3/30/05 indicated that the resident had developed a 4 x 5cm hard black eschar area to the left heel and a 3 x 4 cm hard black eschar area to the right heel. Review of the treatment kardex dated 5/1/05 to 5/10/05 indicated that R #5's heels were to be elevated on a pillow while in bed and dressings to both heels. During constant observations between the hours 5:40 AM to 10:30 AM on 5/10/05, a total of four hours and fifty minutes (4 hrs 50 minutes), R #5 was observed to be in bed, lying on her back with hips and lower extremities slightly rotated over to the left side, a blanket between both legs, and foam boots to both feet. Further observations on 5/10/05 at 8:34 AM indicated that NA #4 had raised the head of the bed up so that R #5 was in a sitting position prior to breakfast but that R #5's hips and lower extremities remained in the same position. Interview and a signed statement from NA #1 dated 5/10/05 at 7:25 AM, NA #1 (11-7 shift) identified that she had last provided care and repositioned R #5 between 4:30 to 5:00 AM. Interview and a signed statement from NA #4 (7-3 shift) dated 5/10/05, identified that she had removed a pillow from behind R #5's left back, prior to sitting the resident up in bed for breakfast, but had not repositioned R #5's hips and/or lower extremities between the hours 7:00 AM to 10:30 AM.

c. Resident #2's Minimum Data Assessment dated 12/13/04 and the MDS assessment dated 3/12/05 identified the resident as severely cognitively impaired, unable to make self understood, required total care by staff for all needs, had a pressure ulcer and was incontinent of bowel and bladder. The care plan dated 12/23/04 and 3/24/05 identified that the resident was at risk for alteration in skin integrity due to immobility and incontinence with interventions that included to turn, reposition every two to three hours and prn, perform skin assessments as per policy and notify MD of any problems. Observation of the resident on 5/10/05 at 5:48 AM identified that the dressing on the left buttocks was discolored, wet with urine and stool was noted on the edges of the dressing. The nurse aide (NA #5) stopped care when the resident was urinating and having bowel movement, both of which went on the pressure ulcer dressing. Following the administration of

incontinent care, NA #5 placed the resident on the left side for a period of three hours and ten minutes. Constant observation of the resident on 5/10/05 during the period of 5:50 AM through 9:00 AM identified that the resident failed to be repositioned off her left side. At 9:05 AM the resident was positioned on her back. In addition, although the left buttocks pressure ulcer dressing was observed to be wet urine and had stool on the edges of the dressing, at 5:48 AM on 5/10/05, the 11-7 LPN did not change the dressing and the 7-3 LPN did not change the resident's dressing until 11 AM on 5/10/05. (5 hours and two minutes). Interview with the day nurse aide (NA #6) and the day LPN (LPN #5) and the charge nurse (RN #1) on 5/10/05 identified that no staff had informed them that the resident's left pressure ulcer dressing had been wet since 5:48 AM.

d. Resident #4's MDS assessment dated 2/28/05 identified the resident as cognitively impaired, requiring extensive staff assistance for bed mobility, incontinent of urine and stool and had no pressure or stasis ulcers. The resident had peripheral vascular disease (PVD) cerebral vascular accident (CVA) and dementia. The care plan dated 2/28/05 identified that the resident had an open area on the right heel and a past history of a left heel/Achille's tendon decubitus ulcer. Interventions included turning and repositioning every two to three hours and PRN, heel protectors and to keep the resident's heels off the mattress. The nurse aide assignment sheet for 5/10/05 identified that the resident was to be turned every two hours in bed and that the resident's heels were to be elevated in bed and a bunny boot was to be on the left foot and a foam boot on the right foot at all times. Observation of the resident on 5/10/05 identified the resident to be lying in bed on her back with both heels on the mattress and the left heel lacked a boot, as per the nurse aide assignment sheet. Observation of the resident between the period of 6:10 AM through 9:30 AM on 5/10/05 reflected that the resident failed to be repositioned off her back. Interview with NA #5 identified that she completed care in R #4's room at approximately 5:15 AM. The resident was without the benefit of repositioning off her back for four hours. Upon inquiry of the 11-7 nurse (LPN #4) she replied that the resident required no protective "heelbo" (protective cushion) to the left heel but has one for the right heel. Observation of the resident's room revealed a protective heel device under pillows which were positioned on the resident's bedside chair. While the 7-3 nurse aide (NA #7) was providing morning care to the resident, the aide was asked whether the resident had any boot to the left foot. The nurse aide replied that she didn't know, she didn't usually work on this unit. Observation of the resident at 9:15 AM on 5/10/05 identified that the protective heel boot was placed on the resident

and subsequent interview with the DNS identified that she had placed the boot on the resident's left foot. In addition, Interview and the statement from the Wound Care Nurse at 9:30 AM on 5/10/05 identified that Resident #4 had a 3.5 cm by 2.0 cm purple-colored area on the left Achilles tendon which the Wound Care Nurse identified as "new" and stated she had not seen it last week. Resident #4's right heel dressing lacked a date to identify the last time the dressing was changed, as per policy and procedure. Observation of the right heel reflected the presence of an odor. The Wound Care Nurse described the right heel as having a faint odor, thick yellow drainage, and a thick black eschar measuring 8 cm by 4 cm in size. The Wound Nurse identified that the right heel looked worse than one week ago. The resident was sent to the wound care clinic on 5/10/05 and nursing documentation on the referral to the clinic identified that the left Achilles was slightly discolored and the resident said it was painful. The wound care note/instructions identified that the left Achilles tendon had a scar from previous ulcer with no new wounds or area of concern and directed staff to use the waffle boots at all times. In addition the pressure ulcer on R #4's right heel was identified as facility acquired on 2/28/05 and described as an eschar with some black areas at edges and measuring 5 cm in size. The nurse's note of 2/28/05 identified that the resident's shoe was kept off the right foot. The care plan dated 2/28/05 identified that there was an "open area" on the right heel. Although there is a physician's note dated 3/1/05, which identified "ulcer", treatment intervention to the right heel ulcer were not initiated by the physician until 3/11/05. The resident had a previous physician's order dated 6/18/03 for "Bunny Boots" to bilateral heels while in bed and another order dated 2/18/05 to check the right heel every shift. Specific treatment to the area of eschar was lacking until 3/11/05 when a protective dressing to the right heel was ordered. On 3/10/05 facility pressure ulcer documentation identified that the right heel now had a depth of 0.1 cm. On 3/16/05 the right heel increased in size to.5 cm by 7 cm and a new treatment and/or communication with the physician was lacking until 3/25/05 when a Normagel protective dressing was ordered. On 4/5/05 the right heel had a faint odor heel cultures dated 3/31 and 4/8/05 identified staph aureus and antibiotics were administered. On 4/11/05 the resident was admitted to the hospital. The hospital record identified that the resident presented to the hospital with a "foul smelling" right heel ulcer and pain in bilateral lower extremities. The resident was treated with intravenous antibiotics and discharged back to the nursing home on 4/15/05. Review of the clinical record, 24 hour report, treatment kardex, nurses notes, physician orders, treatment notes, care plan and care

planning notes with the DNS, ADNS/Wound Care Nurse, Administrator and Corporate Nurses on 5/12/05 identified that there was no documentation to reflect a treatment to the 2/28/05 right heel eschar until the dressing order of 3/11/05 and when the right heel ulcer increased in size on 3/16/05 a treatment order was obtained on 3/25/05. In a meeting with facility staff on 5/18/05 they identified that the resident was seen by MD #1 on 3/1/05, that the resident was evaluated for "diabetic shoes" on 3/2/05, and that the podiatrist saw the resident on 3/11/05, 3/25/05, and 4/8/05. Facility staff identified that the right foot eschar was "chronic" and "stable" and that no invasive treatment was planned due to the diagnosis of PVD.

e. Resident #3's MDS assessment dated 2/8/05 identified the resident as being cognitively impaired, requiring total care by staff for all needs, continent of bowel and bladder and having a stage three pressure ulcer. Resident diagnosis included insulin dependent diabetes mellitus, pressure ulcer, optic neuritis with diminished vision, colostomy and multiple sclerosis with partial paraplegia. The care plan dated 2/8/05 identified the presence of a decubitus ulcer with interventions that included turning and position every two hours and evaluate effectiveness of treatments as ordered. The nurse aide assignment sheet for R #3 directed to turn the resident every two hours. Observation of the resident on 5/10/05 during the period of 6 AM through 8:21 AM identified that the resident was lying in bed on her right side. Interview with the resident on 5/10/05 identified that she was repositioned at 5 AM on 5/10/05 but prior to that she had not been repositioned since the 3-11 shift had last repositioned her. (six hours) The resident lacked repositioning from 11 PM on 5/9/05 through 5 AM on 5/10/05 (six hours) and lacked repositioning from 5:01 AM to 8:25 AM on 5/10/95 for a total of three hours and twenty-five minutes. Nurse Aide (NA #2) stated during interview that she was assigned to care for R #3 and initially stated she turned R #3 at 1:15 AM on 5/10/05 and that NA #5 helped her. Upon request of the nurse aide for a sworn statement, the nurse aide stated she didn't turn R #3 at 1:15 AM but moved the resident's feet. A subsequent interview with the resident on 5/10/05 identified that she sometimes refuses to turn but stated on the 11-7 shift (5/9 into 5/10/05) staff did not offer to reposition her every two hours. In addition, the weekly nursing skin integrity assessment for R #3 dated 4/5/05 identified that the resident's coccyx pressure ulcer had changed from a stage three to a stage four pressure ulcer. Documentation of communication with the physician and/or new treatment interventions were lacking until 5/6/05 when a wet to dry dressing was ordered Upon interview with The Director of Clinical Operations, DNS, Corporate Nurse

#1 and the Administrator on 5/18/05 as to why there was no documentation of physician notification when Resident #3's pressure ulcer deteriorated from a stage three pressure ulcer to a stage four pressure ulcer on 4/5/05 the above staff identified that it was always a stage four from last year and the nurse incorrectly staged the pressure ulcer as a stage three instead of a stage four. Review of the weekly nursing skin integrity assessment during the period of 10/4/04 through 3/28/05 identified that RN #1 had assessed the pressure ulcer on Resident #3 to be a stage three ulcer. On 4/5/05, the Wound Care Nurse/ADNS identified the pressure ulcer to be stage four. Interview with RN #1 on 5/24/05 identified that she was informed by the ADNS that she had incorrectly staged Resident #3's pressure ulcer as a stage 3 instead of stage 4 and was inserviced on this by ADNS. In addition, on 4/26/05 R #3's pressure ulcer's depth increased in size from 3.7 cm on 4/18/05 to 4 cm with a one cm shelf and the presence of a mild odor. A review of a 3/3/05 body scan identified that Resident # 3 had findings indicative of osteomyelitis of the coccyx. Physician orders identified the use of antibiotics for a one-month period (3/9-4/10/05). On 4/4/05 the resident was seen by MD #2 (plastic surgeon) and the physician identified that the resident required a flap closure of the pressure ulcer. The facility's policy and procedure for physician notification identified that when there is deterioration in a wound, the physician should be notified. Documentation was lacking of interventions and/or communication with the physician until 4/29/05 when nursing notes identified the presence of purulent drainage in the coccyx pressure ulcer. Upon interview on 5/12/05 and record review with the DNS, ADNS/Wound Care Nurse, Administrator and Corporate Nurses, the facility could not provide documentation that the physician was informed of the deterioration in the pressure ulcers on above noted dates. Interview with MD #3 on 5/24/05 identified that the facility informs him frequently of changes in the resident's skin and could not specifically recall whether he was informed of the odor and increase in depth/shelf in Resident #3's coccyx pressure ulcer on 4/26/05 but that he may not have ordered a new treatment based on that information. Interview with MD #2 (plastic surgeon) identified that the flap closure had not occurred because he wanted time for the wound (coccyx pressure ulcer) to be healthier looking and to contract so the surgery would be more successful. A review of the facility's Unit Based Weekly Pressure Ulcer Monitoring Form identified that eleven residents developed facility acquired pressure ulcers during the months of March and April, 2005. Upon inquiry of the DNS, ADNS/Wound Care Nurse, Administrator, and two Corporate Nurses, the facility identified that some resident's conditions are

deteriorating. Staff identified that all residents have pressure relieving mattresses, that the facility does weekly Braden Scale assessments on all new admissions, that weekly skin care rounds are conducted by ADNS/Wound Care Nurse, Dietitian and Treatment Nurses to evaluate any resident who has skin breakdown. Upon inquiry as to who was monitoring the turning and repositioning of residents, the above staff identified that the charge nurse performs this task. Staff further identified that the Corporate Nurse is evaluating the repositioning twice a week. Based upon findings related to pressure ulcers, the facility provided an Action Plan which identified that Nursing Supervisors and Unit Managers would be inserviced on physician notification regarding deterioration in wounds and this will be communicated to all licensed nurses on their next scheduled work day. The facility will also review and/or revise, as applicable all policies and procedures related to physician notification, care planning and pressure ulcer assessments to include in inservice instruction. Upon surveyor revisit on 5/17/05, the facility had implemented their Action Plan and no additional findings related to pressure ulcers were identified.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(C).

7. For one resident, (Resident #2) with an identified infection, the nurse aide failed to implement appropriate infection control practices. The findings are based on observation, clinical record review and staff interviews.
    a. Resident #2's Minimum Data Assessment dated 3/12/05 identified the resident as severely cognitively impaired, unable to make self understood, requiring total care by staff for all needs, had a pressure ulcer and was incontinent of bowel and bladder. The care plan dated 12/23/04 and 3/24/05 identified that the resident was at risk for alteration in skin integrity due to immobility and incontinence with interventions that included to turn, reposition every two to three hours and prn, perform skin assessments as per policy and notify MD of any problems. A wound culture of the left buttocks pressure ulcer, dated 3/10/05 identified E-coli and MRSA (methicillin resistant staph aureus). Observation of incontinent care on 5/10/05 by NA #5 identified that the nurse aide provided incontinent care to Resident #2 following incontinence of urine and stool. Upon completion of care, the nurse aide removed the soiled linens with her soiled gloves, proceeded to move a clean box of gloves which was situated on top of the soiled linen hamper,

put the soiled linens in the hamper, remove her gloves and failed to wash her hands before going to obtain a clean johnny from the linen container. Upon interview with the nurse aide on the above noted observation, the nurse aide responded that she should have put the box of clean gloves on top of the hallway railing.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(K) and/or (2)(M).

8. Based on clinical record reviews and staff interviews, for 6 of 19 records reviewed, the facility failed to ensure that documentation was accurate and/or complete (R #1, R #2, R #12, R #16, R #18, R #19). The finding include:
   a. Resident #1 was admitted to the facility on 10/19/04 with diagnoses that included discitis, peripheral vascular disease, end stage renal disease and was receiving hemodialysis three times a week. The resident assessment dated 10/19/04 identified that the resident had impaired cognition, moderate back pain, requiring a limited assistance with bed mobility, non-ambulatory and no pressure ulcers. Review of a treatment note dated 11/4/04 indicated that R #1 had developed a 5.5cm fluid filled blister to the left outer heel secondary to friction with nursing interventions that included a dressing change every day, puff boots at all times and to monitor the left heel for signs and symptoms of infection and deterioration on a daily basis. Review of a weekly nursing skin integrity assessment sheet dated 1/10/05 indicated that the blister on the left outer heel had gone from a Stage 2, dry white tough skin to a Stage 4, thick dry black tissue but there lacked documentation to reflect that the physician had been notified of the change. Further review of the weekly nursing skin integrity sheet indicated that the pressure ulcer to the left heel had increased in size on 2/1/05 (4 x 3cm), 2/8/05 (5 x 3.5cm), 2/14/05 (5 x 2cm) and on 2/21/05 (6cm). A review of the clinical record lacked documentation that the physician had been notified when the left heel ulcer increased in size. Although facility staff (Administrator and DNS) and MD #1/Medical Director identified that they had informed the Medical Director of the changes noted in R #1's left heel pressure ulcer.

      In addition: Review of a nursing skin integrity assessment sheet dated 10/26/04 indicated that R #1 had a Stage II pressure ulcer to the coccyx, measuring 2.5cm in size and 0.1mm in depth. Although the coccyx pressure ulcer healed on

12/27/04, a review of the nursing skin integrity assessment dated 11/11/04 indicated that the pressure ulcer on R #1's coccyx had increased in size to 2.5 x 2.2cm, 0.2mm in depth, had yellow slough tissue in the wound bed, scant serous sanguineous drainage and odor under the dressing. Documentation was lacking to reflect that the physician was notified of the above increased in size to the coccyx pressure ulcer on 11/11/04 when the coccyx pressure ulcer had an increase in size, depth, drainage, and odor. Although interview with MD #1/Medical Director identified that staff are always calling him about changes in skin condition, there lacked any communication between nursing staff and the physician when there was a deterioration (change in size, depth, drainage and odor) in the resident's coccyx ulcer. In addition, a review of the communication documents between the nursing home and dialysis unit lacked documentation in Resident #1's clinical record that the pressure ulcer was communicated to the dialysis unit.

b. Resident #12's diagnoses included central cord syndrome, cervical spondylosis with myelopathy and cerebral vascular accident. R #12's quarterly assessment dated 1/29/05 identified that the resident was alert, oriented, required an extensive assistance with bed mobility, non-ambulatory, utilized a custom wheelchair for locomotion on and off the unit and had no pressure sores. A review of a Nursing Skin Integrity Assessment sheet dated 4/11/05 indicated that the resident had developed a Stage IV thick dry white callous pressure ulcer to the left heel, measuring 6 x 3 x.0.1cm in size, with a 3 x 0.25cm deep purple area extending across the heel. Further review of the Nursing Skin Integrity Assessment sheet dated 4/11/05 indicated that the Assistant Director of Nurses/Wound Nurse had reviewed and initialed the documentation. The ADNS/Wound Nurse on 5/17/05 at 3:35 PM stated that the information written on the Nursing Skin Integrity Assessment sheet identifying the left heel as a Staged IV pressure ulcer was inaccurate. The ADNS/Wound Nurse stated that R #12 has a callous area to the heel and that the deep purple area identified on 4/11/05 looked more like a bruise, which probably had been caused by the footrest on the wheelchair. The ADNS/Wound Nurse stated that R #12 had been reevaluated on 4/25/05 by the sales representative for adjustments to R #12's wheelchair. The ADNS/Wound Nurse stated that she did not know why the heel had been staged as a Staged IV, but that she was responsible to complete and verify the accuracy of information written on the Nursing Skin Integrity Assessment.

c. Resident #2's physician order dated 3/16/05 required Mesalt treatment to the left buttocks pressure ulcer. The facility's 24 hour report dated 3/28/05 identified that

the Mesalt was unavailable and that the pressure area was worse and that the nurse applied a wet to dry dressing. A review of the physician orders during the period of 3/28/05 through 5/12/05 lacked documentation that the physician was informed when Mesalt was unavailable on 3/28/05 and/or that the physician ordered a wet to dry dressing to the left buttocks pressure ulcer. Subsequent to surveyor inquiry, a nurses note dated 5/17/05 identified that on 3/28/05 Mesalt was unavailable for Resident #2, the physician was notified and a wet to dry dressing was used on the dressing until the Mesalt was available the next day. Interview with the DNS, Vice President of Operations, Administrator and Corporate Nurse on 5/18/05 identified that the nurse on 3/28/05 forgot to write the order for the wet to dry dressing.

d. The weekly nursing skin integrity assessment and/or treatment notes identified that Resident #2 had a new stage two pressure ulcer on the left buttocks noted on 2/8/05. A treatment to this area was obtained on 2/8/05. On 2/16/05 a new treatment order was obtained from the physician to the pressure ulcer. On 2/20/05 the pressure ulcer increased in size to 5 cm by 3 cm and was described as "worse". The physician's order dated 2/25/05 directed that Accuzyme followed by a dressing be applied to the left buttocks (pressure ulcer) for seven days. A review of physician's orders during the period of 2/26/05 through 3/9/05 identified a physician's order was lacking for a treatment to the resident's left buttocks pressure ulcer. A review of the treatment kardex for February and March 2005 identified that the Accuzyme dressing continued to be applied to the left buttocks without a physician's order. In addition, documentation was lacking that a treatment to the left buttocks was performed on March 4, March 7, March 15 and March 16, 2005.

e. Resident #16 (R #16) was admitted to the facility on 4/28/05 with diagnoses that included colitis and recent hospitalization for dehydration. Review of the Resident Care Plan (RCP) dated 4/28/05 identified that R #16' had a potential for dehydration with interventions that included monitoring of fluid intake and output. Review of the medical record identified that documentation of fluid intake and output from 4/28/05 through 5/17/05 as well as weekly evaluation of intake and output were inconsistent.

f. Resident #18 (R #18) was admitted to the facility on 5/6/05 with diagnoses that included esophageal cancer and recent hospitalization for dehydration. Review of the Resident Care Plan (RCP) dated 5/6/05 identified that R #18 had a potential for dehydration with interventions that included monitoring of fluid intake and output. Review of the medical record identified that documentation of fluid

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

intake and output from 5/6/05 through 5/17/05 as well as weekly evaluation of intake and output was inconsistent.

g. Resident #19 (R #19) was admitted to the facility on 5/4/05 with diagnoses that included pneumonia and recent hospitalization for dehydration. Review of the Resident Care plan (RCP) dated 5/4/05 identified that R #19 had a potential for dehydration with interventions that included monitoring of fluid intake and output from 5/4/05 through 5/17/05 as well as weekly evaluation of intake and output was inconsistent. Review of the facility's policy for documentation identified that charting would be done on all residents to maintain a complete and accurate medical record. In addition, the policy for intake and output monitoring directed that all nursing personnel were responsible for recording on the Intake and Output (I/O) record and the supervisor and/or Unit Manager would complete the Weekly I/O Evaluation.

STATE OF CONNECTICUT

Exhibit-B

DEPARTMENT OF PUBLIC HEALTH

October 7, 2005

Ms.. Audrey Cushing, , Administrator
Bloomfield Health Care Center
355 Park Avenue
Bloomfield, CT 06002

Dear Ms.. Cushing:

Unannounced visits were made to Bloomfield Health Care Center on August 23, 25,26, 29and 30, 2005 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, and licensing and survey inspections.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by October 21, 2005 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,
Angela B. White

Angela B. White
Supervising Nurse Consultant
Facility Licensing and Investigations Section

ABW:JBG:

c. Director of Nurses
Medical Director
President
vl
Complaint #CT4233, CT4392, CT4386

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and/or (j) Director of Nurses (2)

1. Based on clinical record review, facility documentation and interviews for 1 of 4 sampled residents, R #5, who required assistance with care, the facility failed to ensure assistance was provided in a dignified manner. The findings include:
   a. Resident #5 diagnoses included depression, and history of amputations of two toes on the right foot. A quarterly assessment dated 4/27/05 identified that the resident was not cognitively impaired, and was totally dependent on staff for all activities of daily living except for eating. The plan of care dated 5/19/05 identified a problem with behavior, mood and psychiatric drug use. Interventions included, all staff provide support and reassurance and all provide a calm consistent tone to reorient. Facility documentation dated 5/21/05 identified R #5 complained of poor treatment by a nurse aide #3(NA#3). The documentation noted NA #3 was verbally impatient with R #5's request. Interview with R #5 on 8/23/05 at 1:30 PM identified NA #3 spoke rudely to her on 5/51/05. Interview with NA #3 on 8/25/05 at 5 PM noted the nurse aide denied the allegation.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

2. Based on clinical record review and interviews for 1 of 2- residents,(R #6) who required assistance to attend a medical appointment, the facility failed to ensure staff was available to accompany the resident to the appointment. The finding include:
   a. Resident #6 had diagnoses that included non- insulin dependent diabetes and a stage 4 pressure ulcer. The quarterly assessment dated 6/9/05 indicated severe impaired cognition, resistance to care, required total assistance for activities of daily living, stage 4 pressure ulcer and incontinence. Clinical record review identified the resident had an appointment on 8/9/05 with the wound clinic. Nurse's note dated 8/9/05 indicated the appointment was cancelled. and rescheduled for 8/11/05. Interview with Registered Nurse #1 on 8/26/05 at 10 AM indicated Resident #6 's medical condition required a staff member to be in attendance. Further interview with RN #1 identified, although a staff member was to accompany the resident to the appointment, one was not assigned. A family member was noted to accompanied the resident. The interview further indicated that R #6's family member cancelled at the last minute and the facility was unable to provide a staff

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

member to accompany the resident. As a result, R #6's appointment was rescheduled for 8/11/05.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

3. Based on clinical record review and staff interview for 1 of 2 sampled residents (Resident #1) with a decline in bowel function, the facility failed to assess the resident for the decline in bowel status. The findings include:
   a. Resident #1 ' s diagnoses included diabetes and osteoarthritis. A quarterly assessment dated 9/5/05 identified the resident as having no problem with short and long term memory and continent of bowel function. A significant change assessment dated 12/8/04 and a quarterly assessment dated 6/6/05 identified the resident as incontinent of bowel almost all of the time. Review of the flowsheet for May 2005 through June 2005 identified the resident as incontinent of bowel. Record review and interview with the Licensed Practical Nurse(LPN #1) on 8/25/05 at 10:55 am failed to identify that the resident was assessed for the decline in bowel function. Review of the facility policy noted that a bowel assessment is to be completed when the resident ' s bowel function changes.

4. Based on clinical record review and staff interview for 3 of 23 sampled residents (R #3, #9 and #11), the facility failed to ensure the plan of care was comprehensive. The findings include:
   a. Resident #1 ' s diagnoses included diabetes and osteoarthritis. A quarterly assessment dated 9/5/05 identified the resident as having no problem with short and long term memory and continent of bladder and bowel function. A significant change assessment dated 12/8/05 and a quarterly assessment dated 6/6/05 identified the resident as incontinent of bowel almost all of the time and having multiple daily incontinent episodes of urine. Review of the care plan with LPN #1 on 8/25/05 at 10:55 AM failed to identify that a care plan had been developed to address the resident ' s bowel incontinence.
   b. Resident # 9 ' s diagnoses included Alzheimer's dementia with behavior disturbances. An annual assessment dated 2/2/05 identified the resident as having a short and long term memory problem and moderately cognitively impaired. It also identified the resident as continent of bladder function. A significant change assessment on 5/2/05 identified the resident as having bladder incontinent episodes daily and a quarterly assessment dated 7/27/05 identified the resident as having one to two episodes per week of urinary incontinence. Review of the interim care plan

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

notes dated 5/4/05 identified that the resident had increased incontinence and an increase need for the staff to perform activities of daily living. Review of the resident's care plan with LPN #1 on 8/23/05 at 3:00pm failed to identify that a care plan had been developed to address the resident's urinary incontinence.

c. Resident #11 diagnoses included mental retardation, status post colectomy with colostomy and ileostomy. An admission assessment dated 8/8/05 identified the resident with poor decision making skills, limited abilities in making concrete requests and exhibiting moderate pain on a daily basis. Care plan dated 8/12/05 identified a problem with alteration in skin secondary to ileostomy/colostomy and excoriated abdomen. Review of nurse's notes dated 8/8/05 identified the resident as agitated with ileostomy/ colostomy care and attempting to bite and scratch staff. Observation of ostomy and skincare on 8/25/05 at 10:10 AM with the treatment nurse and unit manger identified that R #11 became combative, that is, striking out and kicking. The resident's abdomen surrounding the ostomy site was observed to be excoriated and when touched by staff the resident retracted away. Review of the plan of care dated 8/12/05 identified the problem of alteration in skin, but interventions regarding pain during treatment an care of the ostomies and excoriated abdominal skin was not addressed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(A).

5. Based on clinical record review and interview for 1 of 8 residents,(R #3 who was resistive to care, the facility failed to revise and review the plan of care to reflect the behavior. The finding include:
   a. Resident #3 diagnoses included recurred seizures, hypertension and non-insulin dependent diabetes. A quarterly assessment dated 6/24/05 identified the resident was cognitively impaired and occasionally exhibited resistance to care. A care plan dated 6/27/05 identified a problem of resistance to care with interventions that included, allowing the resident to make her own decisions and attempt care again. Nurse's narrative note dated 8/19/05 at 2PM identified that the resident had refused a wheelchair cushion in the past. Interview with Registered nurse #2 on 8/25/05 at 11:10 AM identified the resident was reluctant to change position or return to bed. Interview and review of the clinical record with the Minimum Data Set Coordinator on 8/25/05 at 3:40 PM failed to identify that the plan of care was revised to address R #3's refusal of treatment and that alternative interventions were attempted.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A)

6. Based on clinical record review, observations and interviews for 1 of 14 sampled residents, R #17, who was diagnosed with a pressure ulcer, the facility failed to repositioned the resident in a timely manner. The findings include:
   a. Resident #17's diagnoses included diabetes, stroke, depression and anemia. An annual assessment dated 6/6/05 identified the resident had moderate cognition impairment and was totally dependent on staff for activities of daily living. It also identified the skin was intact. Review of the clinical record identified the resident had a stage 2 left buttock pressure ulcer that healed 8/23/05. The plan of care dated 8/16/05 directed the resident to be repositioned every two hours. Constant observation on 8/25/05 from 9:30 AM to 1:15PM (a total of three hours and 45 minutes) identified the resident remained seated in the wheelchair without the benefit of a position change. At 1:15 PM R #17 was mechanically lifted from the wheelchair for approximately thirty seconds. The resident was then placed back into the wheelchair. Constant observation continued and at 3:21 PM the resident was mechanically lifted (Sarita lift) for approximately thirty seconds. At 3:27 PM the resident was again lifted from the wheelchair for approximately sixty seconds. At 3:45 PM the resident was transferred back to bed via the mechanical lift. During observation of care on 8/25/05 at 4 PM, a circular opened area with a small amount of serous drainage was observed on the resident's left buttock. Facility staff failed to reposition the resident off her buttocks for a total of six hours and forty-five minutes. In an interview and clinical record review with the Director of Nursing on 8/26/05 at 11:45 AM she stated the resident was to have been repositioned every two hours. Subsequent review of the plan of care dated 8/15/05 identified the resident with a left buttock stage 2 opened area that measured 0.5 Centimeter.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

7. Based on observations and staff interview for 2 of 8 sampled residents,(R #2 and #13), who required to be transferred by a mechanical lift, the facility failed to ensure the transfer was properly done. The findings include:
   a. Resident #2's diagnoses included seizure disorder. The quarterly assessment dated 8/9/05 identified the resident with severe cognitive impairment and total

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

dependence on staff for transfers and mobility. The plan of care dated 8/18/05 identified at risk for falls. Interventions included to transfer with two staff persons and a mechanical lift. Facility policy and procedure for the mechanical lift directed in part that two staff must be involved in the transfer. Observation on 8/23/05 at 11:40 AM identified two nurse aides secured R #2 to the mechanical lift. Nurse Aide #1 (NA#1) was observed to operate the lift, lifting the resident off the bed. R #2 was observed to be dangling in the air without the benefit of support from staff. Further observation identified NA #2 stood on the opposite side of the bed, behind the resident's wheelchair. NA #2 was then observed to move the wheelchair to the end of the bed, grabbed the back of the mechanical lift pad and pulled the resident over to the chair where NA #1 lowered the resident into the chair.

i. Resident's #2's plan of care dated 8/18/05 included interventions of utilization of padded side rails. Observations on 8/23/05 at 11:05 AM during AM personal care noted NA #1 repositioned R #2 by pulling on his right arm and leg. The nurse aide was then observed to roll the resident to his side and held him over with one hand. The resident's face was noted to be into the padded side rail. Further observation identified the resident was rolled back and forth several times, each time his face was observed to be into the padded siderail. Interview with NA #1 at 2PM on 8/23/05 identified she pulled R #2's arm and leg because there was no pad underneath the resident, and she needed to roll him over. She further stated she did not realized R #2's face was into the padded siderail.

b. Resident #13's diagnoses included traumatic brain injury. The annual assessment dated 7/26/05 identified the resident with severe cognitive impairment and total dependence on two staff persons for transfer using a mechanical lift. The plan of care dated 8/4/05 identified impaired physical mobility related to severe contractures. Interventions included transfer using a hoyer lift. Observations on 8/23/05 at 11:55AM identified NA #1 and #2 to secure R #13 to the mechanical lift. NA #2 was observed to lift the resident off the bed with the mechanical lift while NA #1 guided the tube feed pole. Further observation identified R #13 dangling in mid air, and turned three times by NA #1 by the feet to position the resident over the chair. R #13 was lowered into the chair by NA #1 who grabbed the back of the mechanical lift pad. Interview with the Director of Nursing on 8/23/05 at 1:30PM stated the second nurse aide should be guiding the resident by holding the upper body.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurse (2) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(C) and/or (t) Infection Control (2)(A).

8. Based on observation, clinical record review and staff interviews for 2 of 14 sampled residents, (R #3, #6, 17) identified with pressure ulcers, the facility failed to follow the procedures to prevent reoccurrence and/or healing of the pressure ulcers. The findings include:
   a. Resident #3's diagnoses included recurrent seizures, hypertension and non- insulin dependent diabetes. A quarterly assessment dated 6/24/05 identified that the resident was cognitively impaired, required limited assistance with transfers and was totally incontinent of bladder. The care plan dated 6/27/05 identified a problem of risk for alteration in skin integrity secondary to incontinence and decreased mobility. Interventions included turning and positioning every two hours, and preventative protective measure a needed, that is padding. Physician's order dated 8/19/05 directed cleansing the opened area on right buttocks with normal saline, dry and apply RepliCare every seventy two hours and as needed until healed. Nurse's narrative note dated 8/19/05 at 2 PM identified that an opened area was noted on the right buttocks and a request was placed to physical therapy to obtain a seat cushion. Review of the pressure ulcer flow sheet dated 8/19/05 identified a stage 2 pressure area on the right buttocks that measured 1 Centimeter by 1 Centimeter by 0.1 Centimeter deep. Observation on 8/23/05 at 11:05 AM and 8/25/05 at 10:05 AM noted that Resident #3 was out of bed an utilized a wheelchair without the benefit of a cushion in the chair. Interview and review of the clinical record on 8/25/05 at 11:35 AM with the Director of Rehabilitation failed to provide evidence that although a seat cushion had been utilized in the past, R #3 was without a seat cushion at this time. Subsequent to surveyor inquiry, R #3 was evaluated by a physical therapist and was issued a gel seat cushion. Interview with the charge nurse on 8/25/05 at 11:10 AM identified that the resident spent most of her day in the wheelchair and was reluctant to change positions.
   b. Resident #6 had diagnoses that included non- insulin dependent diabetes, history of urinary tract infection and stage 4 pressure ulcer. The quarterly assessment dated 6/9/05 indicated severe impaired cognition, resistance to care, required total assistance for activities of daily living, stage 4 pressure ulcer, incontinence and history of urinary tract infection . The plan of care dated 6/15/05 identified alteration in elimination related to urinary tract infection and assistance with grooming and impaired skin integrity, with a left buttock pressure area that had

increased in size. The interventions included, incontinent care every two hours. Physician's order dated 8/29/05 directed in part, the wound to the left buttocks to be packed lightly with Acticoat and covered with Tegaderm. Review of laboratory information dated 3/10/05 identified Eschericia Coli and Enterococcus species of the left buttocks. Observation on 8/30/05 at 10:10AM identified Registered Nurse #3 cleansed the left buttocks with normal saline. RN #3 then took the clean Acticoat and tore off a piece and placed it into the wound without the benefit of changing gloves and/ or washing her hands. Further observation noted Licensed Practical Nurse #4 's gloved hands had smeared R #6's left buttocks wound area with feces. LPN #4 used a dry incontinent soak pad to wipe the area. The area was then covered with Tegaderm. Interview with RN #3 on 8/30/05 at 10:40 AM identified she was unaware she had not changed her gloves after cleansing the wound. Interview with LPN #4 on 8/30/05 at 10:40 AM identified that because the fecal smear was from her glove, and it was just a tiny spot it was okay to utilize the incontinent pad to wipe the area.

c. Resident #17 ' s diagnoses included insulin dependent diabetes, renal failure, cerebral vascular accident and hemiparesis. An annual assessment dated 6/6/05 identified the resident had cognitive impairment and was totally dependent on staff for activities of daily living and required mechanical lift for transfers in an out of bed and was incontinent of bowel and bladder. Review of the clinical record identified the resident had decubiti on the left buttock on several occasions. A care plan dated 8/16/05 identified left buttock stage 2 ulcer with interventions that included turn and position every 2 hours, air mattress on the bed and assess daily for infection or deterioration of area. Physician's order dated 8/15/05 directed the resident treatment to a stage 2 ulcer with Normagel then covered with DuoDerm daily until healed. Review of wound monitoring documentation dated 8/16/05 identified a stage 2 ulcer on the left buttock, measuring 2 Centimeters by 1 Centimeters with healing completed on 8/23/05. During constant observation on 8/25/05 from 9:30 a.m. until 1:15 PM. the resident was seated in a wheel chair without the benefit of a change of position. Further observation identified that at 1:45 PM the resident was lifted from the wheelchair via a mechanical lift for thirty seconds, then reseated in the wheelchair until 3:21 PM when the resident was lifted with a mechanical lift in the physical therapy department two times; thirty seconds and sixty seconds at 3:27 PM. During observation of skin care at 4 PM on 8/25/05, a 0.5 Centimeter ulcer with small amount of serous drainage was noted on the left buttocks. In an interview with the Director of Nursing on 8/26/05 at 11:45 AM she stated the resident should have been repositioned every two hours.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(B).

9. Based on clinical record review and staff interview for 4 of 12 sampled residents (Resident # 1, Resident # 6 Resident #9 and Resident #17) with a decline in bladder function and/or and urinary incontinence, the facility failed to assess the resident for a decrease in bladder function and/or failed to provide care in a manner to prevent urinary tract infection. The findings include:
   a. Resident # 1 ' s diagnoses included diabetes and osteoarthritis. A quarterly assessment dated 9/5/05 identified the resident as having no problem with short and long term memory and being continent of bladder function. A significant change assessment dated 12/8/04 and a quarterly assessment dated 6/6/05 identified the resident as having multiple episodes a day of urinary incontinence. Record review and interview with the Licensed Practical Nurse (LPN #1) noted that a bladder assessment was not done for Resident #1 because the decline in bladder function was attributed to the resident's overall decline in condition. Review of the facility policy noted that a bladder assessment will be completed when the resident ' s bladder status has changed.
   b. Resident #6 had diagnoses that included non- insulin dependent diabetes, history of urinary tract infection and stage 4 pressure ulcer. The quarterly assessment dated 6/9/05 indicated severe impaired cognition, resistance to care, required total assistance for activities of daily living ,stage 4 pressure ulcer, incontinence and history of urinary tract infection . The plan of care dated 6/15/05 identified alteration in elimination related to urinary tract infection and assistance with grooming. The interventions included, incontinent care every two hours and whenever necessary. Observation on 8/23/05 at 12:10PM identified R #6 received incontinent care. Nurse aide #1 was observed to use upwards and downwards motions to clean the periarea. Interview with NA #1 on 8/29/05 at 1:30PM identified R #6 has contractures and it is very difficult to clean the peri area. NA #1 also identified the upward and downward motion was used because she was trying to reach the inner portion of the resident's leg.
   c. Resident # 9 ' s diagnoses included Alzheimer ' s Dementia with behavior disturbances. An annual assessment dated 2/2/05 identified the resident as having a short and long term memory problem and being moderately cognitively impaired. It also identified the resident as being continent of bladder function. A significant change assessment on 5/2/05 identified the resident as having bladder incontinent episodes daily and a quarterly assessment dated 7/27/05 identified the resident as having one to two episodes per week of urinary incontinence. . Record review and

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

interview with the Licensed Practical Nurse(LPN #1) on 8/23/05 at 3:00pm noted that she performs the bladder assessments for the unit and that bladder assessments are done on admission and with a change in bladder function. She also noted that a bladder assessment wasn' t done for Resident #9 because her decline in bladder function was due to her decline in cognitive status. Review of the facility policy noted that a bladder assessment will be completed when the resident ' s bladder status has changed.

d. Resident #17 ' s diagnoses included insulin dependent diabetes, renal failure, cerebral vascular accident, anemia, cardiac ischemia and hemiparesis. An annual assessment dated 6/6/05 identified the resident had cognitive impairment and was totally dependent on staff for activities of daily living and required mechanical lift for transfers in an out of bed. The clinical record identified the resident was readmitted to the facility on 8/15/05 with an indwelling (foley) catheter. A nurses note dated 8/24/05 at 11:20 p.m. identified the resident had hematuria, the urine was positive and Cipro an antibiotic was ordered to be 250 Milligrams to be given twice daily for 10 days. Observation of the resident on 8/25/05 at 9:45 AM. identified white sediment and dark amber urine visible inside the catheter tubing. During observation of care on 8/25/05 at 3:55 PM. two nurse aides(NA #4 and #5) transferred the resident via mechanical lift. The aides positioned the resident ' s hands one on top of the other, placed a folded towel over them then placed the foley drainage collection bag on top of the towel effectively placing the bag at the resident ' s chest level. In an interview with nurse aide # 4 on 8/25/05 at 3:57 PM she stated the foley bag was placed that way because she did not want it to hang down. In an interview with the Infection Control Nurse on 8/26/05 at 1:55 PM. she stated the foley bag should always be kept at a level below the bladder.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(C).

10. Based on clinical record review, facility documentation review and interviews for 1 of 8 sampled residents who had inappropriate behaviors, the facility failed to provide a safe environment. The findings include:
    a. Resident #14's diagnoses included schizophrenia. An assessment dated 8/18/04 identified that the resident was cognitively impaired, had altered perceptions and wandering behavior. The care plan dated 8/26/04 identified a problem with wandering into others resident's rooms. Interventions included observe whereabouts of resident every fifteen minutes. Facility documentation dated 9/5/04 identified that R #14 was attacked by R #27 with a plunger. Resident #14

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

defended himself and threw R #27 to the floor. No injuries was noted to either parties. Interview on 8/29/05 at 1:20PM with a maintenance man identified he would leave one plunger in the B wing shower room so that housekeeping could get it without calling the maintenance department.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurse (2) and/or (m) Nursing Staff (2)(C).

11. Based on clinical record review, facility documentation and interviews for one of six residents (Resident 7) with wandering behaviors and/or (Resident #19) who required total assistance with transfers, the facility failed to ensure adequate supervision was provided. The findings include:
    a. Resident #7 had diagnoses that included dementia and Insulin Dependent Diabetes. The quarterly assessment dated 7/6/05 indicated moderate impaired cognition, mood not easily altered, resistance to care, verbally abusive and independent with ambulation. The plan of care dated 7/13/05 identified the risk of wandering and /or elopement out of the facility and increased agitation whenever the Wanderguard was placed on the ankle. The interventions included, Wanderguard to the left or right wrist, and monitoring whereabouts as needed. Nurse's narrative note dated 8/2/05 indicated at 10:30 AM staff was unable to locate Resident #7. Interview with Facility Coordinator on 8/26/05 at 9:10 AM indicated she had seen R #7 in the lobby and redirected him back to his unit. At that time she notified Licensed Practical Nurse # 2. Interview with the Admission Coordinator on 8/26/05 at 9:15 AM indicated she escorted R #7 to an activity on 8/2/05 after he was seen in the lobby. Interview with Registered Nurse # 4 on 8/26/05 at 9 AM and review of facility documentation dated 8/2/05 identified R #7 was observed on camera in the front lobby to hold the Wanderguard on his wrist above the shoulder. Interview with the Wanderguard vendor on 8/29/05 at 11:10 AM indicated the system in place on 8/02/05 required the transmitter to be on the ankle. Interview with the Administrator on 8/26/05 at 11:00 AM indicated although a receptionist was in the lobby on 8/2/05 she was unaware R #7 had exited the building. R #7 was located seven hours later several towns away by the local police. The resident was sent to the emergency room for evaluation and returned to the facility at 7:45 PM. Although the resident did not sustain any injury, the resident's blood sugar was noted to be 240 Mg/dl in the emergency room. Clinical record reviewed noted on 8/1/05 the resident's finger blood sugar was 148 mg/dl.
    b. Resident #19 annual assessment dated 10/3004 that identified poor sitting balance and a quarterly assessment dated 12/31/04 that identified the resident was severely

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cognitively impaired and required total assistance with transfers. Review of physician's orders dated 12/22/04 directed the resident to utilize a mechanical lift (Hoyer) for transfers. Clinical record review identified nurse's narrative note dated 1/6/05 at 4:20 PM that indicated R #19 sustained a 1.5 Centimeter skin tear to the forehead during a mechanical lift transfer. The area required to be steri stripped to remain closed. Interviews with Nurse Aide #7 on 8/29/05 at 3:05 and 3:30 PM identified the resident was seated in her customized wheelchair and which included a seatbelt was being hooked up to the mechanical lift, when her body went forward hitting her head on the bar. NA #7 further stated that the resident was seated upright in the customized wheelchair and her body/trunk was supported at the time she moved forward. NA #7 could not recall whether the seatbelt remained attached to R #19 during the transfer.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (q) Dietary Services (2)(C).

12. Based on facility documentation, observations and interview, the facility failed to label, store and /or dispose leftover food according to facility's policy. The findings include:
    a. During a tour of the facility on 8/23/05 at 9:20 AM with the Food Service Director observations of the walk -in refrigerator identified a tray of sandwiches that were not dated; a plastic container of canned apple rings with a clear wrapper was dated 6/11/05, roast beef on a plate was dated 8/10/05; and a few slices of ham on a plate was dated 8/10/05. An interview on 8/20/05 at 9:30 AM identified facility policy regarding left over food including sliced sandwich meat to be used within four days.
    b. Review of the facility's undated policy on proper handling of leftover food with the FSD on 8/25/05 at 1:12 PM identified that: 1. leftovers will be used within 72 hours or discarded; and 2. All leftovers will be carefully covered, identified, and dated, and placed under refrigeration. Interview with the FSD at this time noted that she had discarded the sandwiches and other foods observed as outdated on 8/23/05.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (t) Infection Control (2)(A).

13. Based on clinical record review, observation and interviews for 1 of 14 residents, R #6 who had a pressure ulcer, the facility failed to ensure the treatment was done to prevent infection and/ or contamination. The finding include:

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

a. Resident #6 had diagnoses that included non- insulin dependent diabetes, history of urinary tract infection and stage 4 pressure ulcer. The quarterly assessment dated 6/9/05 indicated severe impaired cognition, resistance to care, required total assistance for activities of daily living, stage 4 pressure ulcer, incontinence and history of urinary tract infection . The plan of care dated 6/15/05 identified alteration in elimination related to urinary tract infection and assistance with grooming. The interventions included, incontinent care every two hours. Physician's order dated 8/29/05 directed in part, the wound on the left buttocks to be packed lightly with Acticoat and covered with Tegaderm. Observation on 8/30/05 at 10:10Am identified Registered Nurse #3 cleansed the left buttocks with normal saline. RN #3 then took the clean Acticoat and tore off a piece and placed it into the wound without the benefit of changing gloves and or washing her hands. Interview with RN #3 on 8/30/05 at 10:40AM identified she was unaware she had not changed her gloves after cleansing the wound.